National General Accident & Health

Dental Claim Form and Instructions

PLEASE DO NOT SUBMIT THIS FORM FOR PRECERTIFICATION.
PRECERTIFICATIONS ARE NOT REQUIRED FOR YOUR DENTAL POLICY. If you have any questions about completing this form, call the number listed on your id card 7:00 A.M. to 6:00 P.M. Central Standard Time.

INSTRUCTIONS FOR FILING DENTAL CLAIMS

- All claims must be submitted on an American Dental Association (ADA) Claim Form: a form is attached to these instructions.
- Please ask your dentist's office to complete the entire form. Blank fields will cause the claim processing to be delayed. We must have the following information:
  - The policyowner's Dental policy number.
  - The policyowner's complete name as it appears on the Dental Plan ID card.
  - The patient's full name, sex, date of birth and relationship to the policyowner.
  - The treatment date, tooth or surface, ADA code and charge for each procedure.

Please refer to the back of your ID card for claim submission information

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1. ☐ Dentist's pre-treatment estimates Specialty (see backside)
☐ Dentist's statement of actual services

2. ☐ Medicaid Claim Prior Authorization #
☐ EPSDT

3. Carrier Name

4. Carrier Address

5. City | 6. State | 7. ZIP

PATIENT

8. Patient Name (Last, First, Middle)

9. Address

10. City

11. State

12. Date of Birth (MMDDYYYY) ______/______/______

13. Patient ID # / SSN #

14. Sex ☐ Male ☐ Female

15. Phone Number ( )

16. ZIP Code

17. Relationship to Subscriber/Employee:
☐ Self ☐ Spouse ☐ Child ☐ Other ______________________

18. Employer/School
Name ______________________
Address ______________________

SUBSCRIBER/EMPLOYEE

19. Subs. SSN#

20. Employer Name

21. Policy#

22. Subscriber/Employee Name (Last, First, Middle)

23. Address

24. Phone Number ( )

25. City

26. State

27. ZIP

28. Date of Birth (MMDDYYYY) ______/______/______

29. Marital Status ☐ Married ☐ Single ☐ Other

30. Sex ☐ Male ☐ Female

39. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges.

X______________________
Signed (Patient/Guardian) Date (MMDDYYYY)

OTHER POLICIES

31. Is patient covered by another plan?
☐ No (Skip 32-37) ☐ Yes ☐ Dental or ☐ Medical

32. Policy #

33. Other Subscriber's Name

34. Date of Birth (MMDDYYYY) ______/______/______

35. Sex ☐ Male ☐ Female

36. Plan Program Name

37. Employer/School
Name ______________________ Address ______________________

38. Subscriber/Employee Status
☐ Employed ☐ Part-time Status ☐ Full-time Student ☐ Part-time Student

40. Employer/School
Name ______________________ Address ______________________

41. I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity.

X______________________
Signed (Employee/Subscriber) Date (MMDDYYYY)

BILLING DENTIST

42. Name Of Billing Dentist Or Dental Entity

43. Phone Number ( )

44. Provider ID#

45. Dental SS# or T.I.N.

46. Address

47. Dental License #

48 First visit date of current series

49. Place of Treatment ☐ Office ☐ Hosp ☐ ECF ☐ Other

50. City

51. State

52. ZIP Code

53. Radiographs or models enclosed?
☐ Yes, how many?______ ☐ No

If service already commenced: Total months of treatment

Date appliances placed:______________________ Remaining______________________

55. If prosthesis (crown, bridge, dentures), is this initial placement? ☐ Yes ☐ No
If no, reason for replacement.

Date of prior placement

56. If prosthesis (crown, bridge, dentures), is this initial placement? Brief description and dates: ☐ Yes ☐ No
____

57. Is treatment result of: ☐ Auto Accident? ☐ Other accident? ☐ Neither
Brief description and dates:
____

58. Diagnosis Code Index (optional)

1.________ 2.________ 3.________ 4.________ 5.________ 6.________ 7.________ 8.________

59. Examination and treatment plans. List teeth in order.

Date (MMDDYYYY)			Tooth	Surface	Diagnosis Index#	Procedure Code	Qty	Description	Fee	Admin. Use Only

60. Identify all missing teeth with X

Permanent		Primary	
1 2 3 4 5 6 7 8	9 10 11 12 13 14 15 16	A B C D E	F G H I J
32 31 30 29 28 27 26 25	24 23 22 21 20 19 18 17	T S R Q P	O N M L K

Total Fee		
Payment By Other Plan		
Max. allowable		
Deductible		
Carrier %		
Carrier pays		
Patient pays		

61. Remarks for unusual services.

62. I hereby certify that the procedures as indicated by date are in progress for procedures that require multiple visits or have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.

X______________________
Signed (Treating Dentist) License # Date (MM/DD/YYYY)

63. Address where treatment was performed.

64. City

65. State

66. ZIP Code

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FRAUD WARNING NOTICES:

For states not listed below: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subject such person to criminal and civil penalties.

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

Alaska: A person who knowingly and with intent to injure, defraud, or deceive an insurance company, files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

Arizona: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Arkansas, District of Columbia & West Virginia: Warning **-** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

California: For your protection, California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Delaware, Idaho & Oklahoma: Warning - Any person who knowingly and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Indiana: Any person who knowingly, and with intent to defraud an insurer, files a statement of claim containing false,incomplete or misleading information commits a felony.

Kansas: Any person who knowingly files a statement of claim containing any misrepresentation or any false,incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

Kentucky: A person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Maine, Tennessee, Virginia & Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Minnesota: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Ohio: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Texas: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

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